



General

Guideline Title

Urinary incontinence in the long term care setting.

Bibliographic Source(s)

American Medical Directors Association (AMDA). Urinary incontinence in the long term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2012. 33 p. [95 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Urinary incontinence in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2010. 20 p.

Recommendations

Major Recommendations

Note from the American Medical Directors Association (AMDA) and the National Guideline Clearinghouse (NGC): The original full-text guideline provides an algorithm on "Urinary Incontinence in the Long Term Care Setting" to be used in conjunction with the written text. Refer to the "Guideline Availability" field for information on obtaining the algorithm, as well as the full text of the guideline, which provides additional details. Graded recommendations were still being finalized at the time of guideline printing and were thus not available for inclusion in this NGC summary.

Recognition

Step 1

Does the Patient Have a History of Urinary Incontinence (UI)?

Obtain information about the patient's past and present urinary function.

- Review the transfer summary and other chart data for indications of a UI problem.
- Review for recent or prior placement of an indwelling urinary catheter and associated diagnosis.
- Review the results of a previous UI evaluation, if any.
- If the patient has a history of UI, identify the onset and type of incontinence to the extent possible.
- Review all medication changes in the 30 to 90 days before UI is noted, to rule out medication changes as contributing factors.

See the original guideline document for Minimum Data Set (MDS) process recommendations.

Step 2

Does the Patient Show Signs and Symptoms of UI?

UI is identified by direct observation (i.e., by observing an incontinence episode or finding the patient wet).

- Document any signs and symptoms of UI in the patient's medical record.
- Determine how often the patient leaks urine and how much urine is lost (small or large volume).
- Determine whether the patient uses a protective pad, brief, or other absorbent product.

Assessment

Step 3

Identify Factors Affecting the Patient's Urinary Continence

With the interdisciplinary team, assess for risk factors that may affect the patient's potentially modifiable causes of UI (see Table 3 in the original guideline document) so that interventions may be targeted to those factors. Consider the input of the consultant pharmacist in the review of medication effects on continence status.

Step 4

Perform a Physical Examination and an Additional Work-up as Indicated

The primary purpose of the history and physical examination is to detect potentially modifiable or reversible factors that are contributing to the patient's UI. See original guideline document for details of:

- Initial examination
- Targeted physical examination
- Laboratory testing
- Other assessments, including postvoid residual testing, bladder stress testing, prostate specific antigen (PSA) testing, and urodynamic studies

Step 5

Summarize Relevant Information about the Patient's UI

Management

Step 6

Identify Individual Treatment Goals and Develop a Plan of Care

The overall goal should be to improve function and quality of life and decrease episodes of UI. The most basic goals of managing UI are to try to reduce its frequency and severity and to minimize related complications. Effective treatment of underlying causes may not always be possible or pertinent because of a patient's general condition, treatment preferences, or functional abilities. Figure 1 in the original guideline document lists categories of treatment options for specific types of UI.

Step 7

Address Transient Causes of, and Modifiable Risk Factors for, UI

As appropriate, treat transient causes of UI and address modifiable risk factors—both those related to urinary tract function and those that affect urinary function by impairing an individual's overall function, mobility, level of consciousness, and so on. For example, manage delirium, treat urethritis, provide an easily accessible toilet, and offer frequent reminders to toilet and assistance with toileting if necessary.

Patients with symptoms of a UTI or of urosepsis (bacteria in the bloodstream, probably from a urinary source, with signs of sepsis) should receive appropriate treatment. The goal of treating a UTI is, at a minimum, to alleviate systemic or local symptoms. Total eradication of all bacteria may not always be feasible (e.g., in a patient who has an indwelling urinary catheter or other source of chronic bacteriuria).

Long term care (LTC) facilities should have clear policies and practices to ensure that patients are not started on antibiotics without a credible clinical rationale.

Step 8

Provide a Toileting Program as Appropriate

If the patient remains incontinent after transient causes of UI have been treated, consider initiating a toileting program for appropriate patients—that is, a plan whereby staff members at scheduled times each day either take the patient to the toilet, give the patient a urinal, or remind the patient to go to the toilet.

Step 9

Consider Additional or Alternate Interventions as Appropriate

Patients who remain incontinent after a toileting intervention ought to be considered for other interventions depending on the type of UI they are thought to have. Patients may have preferences concerning the type of treatment they wish to receive for UI. When appropriate, they should be asked about such preferences.

See original guideline document for details of:

- Bladder rehabilitation or bladder retraining
- Pelvic floor muscle rehabilitation
- Physiological quieting
- Electrical stimulation

Step 10

Evaluate the Effectiveness of Interventions Thus Far, and Implement Additional Approaches as Indicated

If the measures described in Steps 7 through 9 are not appropriate or do not adequately resolve the patient's UI, consider other possible interventions, including pharmacologic therapy (see Table 6 in the original guideline document for a list of potential pharmacologic interventions according to type of incontinence).

Although they do not address underlying causes, incontinence devices and products may play a limited role in the management of UI or a more significant role if the underlying risks or causes of incontinence cannot be treated.

Some women whose urine retention or incontinence is associated with bladder or uterine prolapse may benefit from the placement of a pessary (an intravaginal device used to treat pelvic muscle relaxation or prolapse of pelvic organs).

Surgery for stress incontinence in women or urinary obstruction in men may be effective in some cases (e.g., transurethral prostate resection or dilation of a urethral stricture may be beneficial in selected cases).

Step 11

Consider Catheterization

If other interventions are not feasible or have not adequately addressed the patient's UI, consider bladder catheterization. Catheterization may be intermittent or indwelling.

Position, secure, and manage an indwelling catheter properly to minimize urethral damage and other complications (see Table 9 in the original guideline document for management guidelines). Use a sterile catheter technique for the initial insertion. Monitor for and manage complications such as pain, bleeding, urosepsis, and catheter blockage.

Monitoring

Step 12

Monitor the Course and Consequences of UI and its Treatment

Specifically, monitor patients for:

- Effectiveness of interventions, using an objective measure of the severity of UI such as systematic recordings or a bladder diary
- Response to any medications initiated to try to control continence
- The appropriateness of changing to a less obtrusive or lower-risk intervention
- Patient satisfaction with treatment

- Side effects or complications of treatment

Step 13

Monitor the Facility's Management of UI

Table 10 in the original guideline document lists sample performance measurement indicators.

Clinical Algorithm(s)

An algorithm for urinary incontinence in the long term care setting is provided in the original guideline document.

Scope

Disease/Condition(s)

Urinary incontinence (UI)

Guideline Category

Diagnosis

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Nursing

Urology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Pharmacists

Physician Assistants

Physicians

Guideline Objective(s)

- To improve the quality of care delivered to patients with urinary incontinence (UI) in long term care (LTC) facilities
- To provide guidelines that focus on UI in the LTC setting

Target Population

Elderly individuals and/or residents of long term care (LTC) facilities with urinary incontinence (UI)

Interventions and Practices Considered

Diagnosis/Evaluation

1. Review of patient history of urinary incontinence (UI)
2. Documentation of signs/symptoms of UI
3. Identification of factors (including modifiable factors) affecting continence
4. Physical examination and additional work-up, as indicated (e.g., postvoid residual testing, urinalysis, bladder stress testing, prostate specific antigen [PSA] testing)
5. Summarization of patient information

Treatment/Management

1. Development of treatment goals and individualized treatment plan
2. Addressing transient causes and modifiable risk factors for incontinence
3. Toileting program
4. Additional or alternate programs including bladder rehabilitation/retraining or pelvic floor rehabilitation
5. Pharmacologic therapy
6. Incontinence devices and products
7. Pelvic support devices
8. Surgery for incontinence
9. Catheterization (intermittent or indwelling)
10. Monitoring the course of UI and its treatment

Major Outcomes Considered

- Continence
- Quality of life
- Side effects/complications of treatment

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The clinical practice committee vice-chair performs a systematic literature search for the topic of the guideline, using the electronic databases

MEDLINE, PubMed, etc. Each year the Steering Committee reviews all American Medical Directors Association (AMDA) clinical practice guidelines that are 3 years old and commissions a thorough literature review to determine whether the content of each guideline remains current. If new literature does not change the content or scope of the original guideline, it is deemed to be current.

For this guideline revision, databases were searched between June 2009 and January 2011 for updated literature related to urinary incontinence in the long term care setting. Inclusion criteria included elderly, long term care, and urinary incontinence topics. The following search terms were used: elderly, long term care, nursing home, urinary incontinence, overactive bladder, urge incontinence, stress incontinence, overflow incontinence, functional incontinence, mixed incontinence, treatment, management, pharmacological treatment of urinary incontinence and overactive bladder, urinary retention, toileting program, urinary catheterization.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality of Evidence

The quality of evidence indicates the extent to which one can be confident that an estimate of effect is correct.

High: At least 1 randomized controlled trial OR 3 pre/post interventions or other prospective interventions or 3 well-structured, relevant observational studies

Moderate: Studies that use well-tested methods to make comparisons in a fair way, but where the results leave room for uncertainty (e.g., because of the size of the study, losses to follow-up, or the method used for selecting groups for comparison)

Low: Studies in which the results are doubtful because the study design does not guarantee that fair comparisons can be made

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Grading System for American Medical Directors Association (AMDA) Clinical Practice Guidelines

Judgments about the quality of evidence (see the "Rating Scheme for the Strength of the Evidence" field) require assessing the validity of results for important outcomes in individual studies. Explicit criteria should be used in making these judgments. In the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) Working Group approach, a systematic review of available evidence guides these judgments.

Sequential judgments are made concerning the following factors:

- The quality of evidence across studies for each important outcome
- Which outcomes are critical to a decision
- The overall quality of evidence across these critical outcomes
- The balance between benefits and harms
- The strength of recommendations

Reviewers consider four key elements: study design, study quality, consistency, and directness.

Definitions

Study design refers to the basic study design (broadly, observational studies and randomized trials).

Study quality refers to the detailed study methods and execution. Appropriate criteria are used to assess study quality for each important outcome. For randomized trials, for example, these criteria might include the adequacy of allocation concealment, blinding, and follow up. Reasons for downgrading a quality rating must be explicit (e.g., failure to blind patients and physicians reduced the quality of evidence for an intervention's impact on pain severity, a serious limitation).

Consistency refers to the similarity of effect estimates across studies. If there is important unexplained inconsistency in study results, confidence in the effect estimate for that outcome is reduced.

Directness refers to the extent to which the people, interventions, and outcome measures in the studies are similar to those of interest. For example, the directness of the evidence may be uncertain if the people of interest are older, sicker, or have more comorbidity than those in the studies. To determine whether important uncertainty exists, one can ask whether there is a compelling reason to expect important differences in the effect size. Because many interventions have more or less the same relative effects across most patient groups, reviewers should not use overly stringent criteria in deciding whether evidence is direct.

Criteria

Criteria for decreasing the grade:

- Serious (-1) or very serious (-2) limitation to study quality
- Important inconsistency (-1)
- Some (-1) or major (-2) uncertainty about directness
- Imprecise or sparse data (-1)
- High probability of reporting bias (-1)

Criteria for increasing the grade:

- Strong evidence of association: Significant relative risk greater than 2 (less than 0.5), based on consistent evidence from two or more observational studies, with no plausible confounders (+1)
- Very strong evidence of association: Significant relative risk greater than 5 (less than 0.2), based on direct evidence with no major threats to validity (+2)
- Evidence of a dose-response gradient (+1)
- All plausible confounders would have reduced the effect (+1)

These criteria are cumulative – e.g., if randomized controlled trials (RCTs) have serious limitations and there is uncertainty about the directness of the evidence, the grade of evidence would drop from high to low.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Original guidelines are developed by interdisciplinary workgroups, using a process that combines evidence- and consensus-based approaches. Workgroups include practitioners and others involved in patient care in long term care (LTC) facilities. Beginning with pertinent literature searches for articles and information related to the guideline subject and a draft outline/framework, each group works to develop a concise, usable guideline that is tailored to the LTC setting. Because scientific research in the LTC population is limited, many recommendations are based on findings from research involving community-living older adults. Some recommendations are based on the expert consensus opinion of practitioners and experts in the field of geriatric medicine.

The American Medical Directors Association (AMDA) Clinical Practice Guideline Steering Committee directs the guideline development and revision process. Each year the Steering Committee reviews all AMDA clinical practice guidelines that are 3 years old and commissions a thorough

literature review to determine whether the content of each guideline remains current. The AMDA Clinical Practice Committee Chair selects the existing guidelines to be revised and new guidelines to be created based on 1) the Steering Committee's recommendations, 2) data collected, and 3) an assessment of the difficulty of development and relevance to the AMDA membership. AMDA's Board of Directors has final approval over this process.

Grading System for AMDA Clinical Practice Guidelines

The system AMDA has adopted for grading clinical practice guidelines (see the "Rating Scheme for the Strength of the Recommendations" field) is based on the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) Working Group Approach.

Sequential judgments are made concerning the following factors:

- The quality of evidence across studies for each important outcome
- Which outcomes are critical to a decision
- The overall quality of evidence across these critical outcomes
- The balance between benefits and harms
- The strength of recommendations

Rating Scheme for the Strength of the Recommendations

Strength of Recommendation

The strength of a recommendation indicates the extent to which one can be confident that adherence to the recommendation will do more good than harm.

- Strong: Benefits clearly outweigh risks.
- Weak: Benefits are balanced with risks.
- Insufficient: Evidence is inadequate to make a recommendation.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

All American Medical Director Association (AMDA) clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long term care setting.

AMDA's guidelines are supported by the following associations/organizations, who are members of its Clinical Practice Guideline Steering Committee. These associations/organizations all have representatives who participate in the external review phase and officially sign off on the guideline before publication: American Association of Homes and Services for the Aging (now LeadingAge); American College of Health Care Administrators; American Geriatrics Society; American Health Care Association; American Society of Consultant Pharmacists; Gerontological Advanced Practice Nurses Association; Direct Care Alliance; National Association of Directors of Nursing Administration in Long Term Care; National Association of Health Care Assistants.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The guideline was developed by an interdisciplinary work group using a process that combined evidence- and consensus-based approaches. Because scientific research in the long term care population is limited, many recommendations are based on findings from research involving community-living older adults. Some recommendations are based on the expert consensus opinion of practitioners and experts in the field of geriatric medicine.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Improved identification through the assessment process of individuals who have modifiable urinary incontinence (UI)
- Improved individualized plans of care to manage UI
- Improved health and quality of life for patients with UI
- More effective staff education and utilization of staff resources for optimally evaluating and managing UI
- Improved staff satisfaction
- Minimization of inappropriate use of absorbent products and indwelling urinary catheters
- Reduction in significant complications of UI and indwelling urinary catheters

Potential Harms

Pharmacologic Therapy

- Consider significant risks and anticipated benefits before prescribing medication for urinary incontinence (UI). Identify other medications in the patient's regimen that may counteract the beneficial effects or exacerbate the side effects of agents prescribed for UI. For example, in patients with urinary obstruction medications with anticholinergic properties may impair continence or cause urinary retention. The concomitant use of cholinesterase inhibitors with anticholinergic medications may reduce the efficacy of both agents and cause significant side effects (see Appendix 2 in the original guideline document for more information on the impacts of different classes of medications on UI).
- All medications used to treat UI can have significant side effects in susceptible patients, including changes in behavior, level of consciousness, and function. Some newer agents may have fewer cognitive side effects, a characteristic that has been ascribed to their selectivity for target receptors in the bladder and lower likelihood of crossing the blood-brain barrier. This is particularly true of hyoscyamine-based (e.g., Anaspaz, Cystospaz, Levbid, NuLev) and atropine-like (e.g., flavoxate, methenamine combination) medications that are sometimes used to treat UI but are generally not appropriate in frail, cognitively impaired elderly patients. Newer extended-release oral antimuscarinics may have fewer side effects than the older immediate-release oral preparations because they achieve steady therapeutic serum levels of the drug. Transdermal preparations may have fewer side effects than oral ones because transdermal delivery, by bypassing the liver, significantly reduces the quantity of circulating drug metabolites.
- Side effects of medications used to treat incontinence are listed in Table 6 in the original guideline document.

Pelvic Support Devices

Monitor the patient with a pessary for effectiveness and complications, remove it periodically for cleaning, and consider discontinuing it if it is ineffective or if significant complications (e.g., infection, bleeding) occur.

Indwelling Catheters

Position, secure, and manage an indwelling urinary catheter properly to minimize urethral damage and other complications (see Table 9 of the original guideline document for details). Use a sterile catheter technique for the initial insertion. Monitor for and manage complications such as pain, bleeding, urosepsis, and catheter blockage. Consider collaboration with a urologist for patients with long term indwelling catheters to evaluate for long term complications and to consider alternative forms of urinary diversion.

Contraindications

Contraindications

Intermittent catheterization is relatively contraindicated and possibly traumatic in cases of outlet obstruction.

Qualifying Statements

Qualifying Statements

- This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical condition of a particular patient. The American Medical Directors Association (AMDA), its heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.
- The utilization of AMDA's Clinical Practice Guideline does not preclude compliance with State and Federal regulation as well as facility policies and procedures. They are not substitutes for the experience and judgment of clinicians and caregivers. The Clinical Practice Guidelines are not to be considered as standards of care but are developed to enhance the clinicians' ability to practice.
- AMDA guidelines emphasize key care processes and are created to be used in conjunction with facility-specific policies and procedures that guide staff and practitioner practices and performance. They are meant to be used in a manner appropriate to the population and practice of a particular facility. Guideline implementation may be affected by resources available in the facility, including staffing, and will require the involvement of all those in the facility who have a role in patient care.
- Long term care facilities care for a variety of individuals, including younger patients with chronic diseases and disabilities, short-stay patients needing postacute care, and very old and frail individuals suffering from multiple comorbidities. When a workup or treatment is suggested, it is crucial to consider if such a step is appropriate for a specific individual. A workup may not be indicated if the patient has a terminal or end-stage condition, if it would not change the management course, if the burden of the workup is greater than the potential benefit, or if the patient or his or her legally authorized representative would refuse treatment. It is important to carefully document in the patient's medical record the reasons for decisions not to treat or perform a workup or for choosing one treatment approach over another.

Implementation of the Guideline

Description of Implementation Strategy

The implementation of this clinical practice guideline (CPG) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

I. Recognition

- Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and feasibility of implementing the CPG

II. Assessment

- Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes

III. Implementation

- Identify and document how each step of the CPG will be carried out and develop an implementation timetable
- Identify individual responsible for each step of the CPG
- Identify support systems that impact the direct care
- Educate and train appropriate individuals in specific CPG implementation and then implement the CPG

IV. Monitoring

- Evaluate performance based on relevant indicators and identify areas for improvement
- Evaluate the predefined performance measures and obtain and provide feedback

Table 10 in the original guideline document provides sample performance measurement indicators (process indicators and outcome indicators).

Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

American Medical Directors Association (AMDA). Urinary incontinence in the long term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2012. 33 p. [95 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1996 (revised 2012)

Guideline Developer(s)

American Medical Directors Association - Professional Association

Guideline Developer Comment

Organizational participants included:

- American College of Health Care Administrators
- American Geriatrics Society
- American Health Care Association
- American Society of Consultant Pharmacists
- Direct Care Alliance
- Gerontological Advanced Practice Nurses Association
- LeadingAge
- National Association of Directors of Nursing Administration in Long Term Care
- The AMDA Foundation

Source(s) of Funding

American Medical Directors Association

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Clinical Practice Guideline Steering Committee

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Financial Disclosures/Conflicts of Interest

All contributors must submit an Accreditation Council for Continuing Medical Education (ACCME) approved disclosure form prior to being accepted as a volunteer member of the guideline workgroup. This disclosure form is reviewed by the chair of the American Medical Directors Association (AMDA) Clinical Practice Committee. If any conflicts are perceived, that person is not accepted to be part of the workgroup.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Urinary incontinence in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2010. 20 p.

Guideline Availability

Electronic copies: Not available at this time.

Print: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com .

Availability of Companion Documents

Table 10 in the original guideline document provides sample performance measurement indicators (process indicators and outcome indicators).

Assessment tools for urinary incontinence are available in the appendixes to the original guideline document.

Patient Resources

None available

NGC Status

This summary was completed by ECRI on July 12, 1999. The information was verified by the American Medical Directors Association as of August 8, 1999. This NGC summary was updated by ECRI Institute on October 4, 2011. The updated information was verified by the guideline developer on November 29, 2011. This NGC summary was updated by ECRI Institute on August 9, 2013. The updated information was verified by the guideline developer on September 27, 2013.

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